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July 24, 2007

Kevin M. Burke
Secretary of Public Safety and Security
Executive Office of Public Safety
One Ashburton Place, Room 2133
Boston, MA 02108

Dear Secretary Burke:

Attached please find Vance's Findings and Recommendations relative to our review of the Office of the Chief Medical Examiner (OCME).

You will note from this report that much work needs to be done at the OCME. The recommendations in the attached document focus on critical areas of the OCME's operations. We strongly believe that these recommendations, at a minimum, must be implemented if the OCME is to successfully move forward.

I hope you find this report helpful. Thank you for giving Vance the opportunity to work on this important project for this critical Commonwealth agency. If you have any questions or would like to discuss our findings and recommendations in more detail, please contact me at (781) 849-1700 or Robert.Sikellis@gardaglobal.com. I look forward to discussing our report and findings in detail with you.

Sincerely,

Robert N. Sikellis

Robert N. Sikellis
Managing Director and Associate General Counsel
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Findings and Recommendations

Office of the Chief Medical Examiner

Prepared for:

The Executive Office of Public Safety
Commonwealth of Massachusetts

July 24, 2007

Submitted by:

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I. Executive Summary

Many of the past reviews and assessments of the Office of the Chief Medical Examiner (OCME), as well as most of its current staff, would blame the OCME's many problems on a lack of funding. Notwithstanding recent increases, lack of funding certainly is one issue contributing to this agency's problems. Lack of funding, however, does not begin to explain the long-term and persistent problems of this agency. Unlimited funding of this agency would not fix it in its current state.

The "model" used to run this agency is broken and has been from the inception of the OCME in 1983. The OCME is an agency that for a prolonged period of time has had little or no effective management or supervision. In its early years, strong management was not available to the office. In more recent times, strong management was available but largely ignored.

Some recent changes at the OCME have been positive. Funding, while still below the national average, has increased substantially in recent years. Exceptionally qualified new medical staff has been added to supplement the existing physicians. The commitment and dedication of the medical staff and quality of the testimony by medical staff, with one notable recent exception, are considered high amongst district attorneys and the judiciary of the Commonwealth.

This has not, however, helped prevent the OCME from reaching where it is today: on the verge of collapse. While the OCME is fulfilling its basic legal responsibilities, it is doing so with great difficulty. The risk of inaccurate determinations of cause of death will increase if immediate corrective measures are not instituted.

The OCME has been so thoroughly mismanaged that it currently lacks the most basic infrastructure necessary to effectively support its core function. The almost absent management and supervision structure in place at the OCME has lead to:

- **No written policies and procedures or standard operating procedures on even the most basic of functions.**
- **Little if any training of employees, even on critical functions.**
- **Little or no focus on basic health and safety issues of employees and visitors.**
- **The increase in discretionary jurisdiction which has substantially increased the work load and brought the OCME to near collapse.**
- **Little or no evaluation of various practices in light of national best practices or budgetary constraints.**
- **A lack of planning for needed resources, programs and systems to deliver effective services and measured results.**
- **The existence of a creeping culture of indifference and a demoralized staff.**

The OCME is in need of a complete organizational overhaul. Historically, the exclusive focus on how to "fix" the OCME has been to appoint the best possible forensic pathologist to oversee the office. The OCME certainly needs a leading forensic pathologist as the Chief Medical Examiner to oversee all medical functions, and the Commonwealth succeeded in this effort in its most recent hire: by all accounts, it hired an amply qualified forensic pathologist to rebuild this OCME.

Rather than rely on existing management, however, the Chief Medical Examiner chose to largely ignore them. Instead of rebuilding the office, the Chief Medical Examiner almost immediately embarked on a program to substantially increase the casework while developing new programs like the ill-fated Medicolegal Investigators Program.

The OCME must immediately begin building the necessary infrastructure for growth. While doing so, it should refocus exclusively on fulfilling its core mission. Most importantly, the rehabilitation and growth of the OCME must include a strong management team, lead by a robust and independent Chief Operating Officer, working with the Chief Medical Examiner. This person should be responsible for overseeing all the non-medical functions of the OCME.

Ours is not a new concept. What may be viewed as new – yet vitally important to the success of the model we are recommending – is that the COO not only oversee all non-medical functions, but have *a level of independent authority and responsibility over these functions*. This critical element has been lacking at the OCME. The report outlines how this should be structured.

II. Overview of the OCME

Introduction

The OCME was established in 1983 pursuant to Chapter 38 of the General Laws of the Commonwealth of Massachusetts. Its purpose is to provide a comprehensive system for conducting death investigation services in the Commonwealth. Prior to 1983, the functions of the OCME were handled regionally, by the individual counties of the Commonwealth under the direction of each District Attorney.

The Chief Medical Examiner has jurisdiction over all cases where the death was due to violence or other unnatural causes as well as where, in his opinion, the death was due to natural causes that require further investigation.

The core function of the OCME is to determine the "cause and manner" of death through the performance of autopsies and laboratory studies. The "cause" of death is the disease process or injury responsible for death. The "manner" of death places the death in one of five categories: natural, homicide, suicide, accident or undetermined.

Office Organization

The OCME staff is organized into five (5) main groups:

1. Medical Staff
2. Medicolegal Investigators
3. Administrative Staff
4. Technical Staff
5. Non-medical Management Staff

The Medical Staff currently consists of 10 Medical Examiners, following the resignation of Dr. Phillip Croft in mid-June of this year, and a Forensic Pathology Fellow who only very recently began work at the OCME. Also on the medical staff of the OCME, though reporting to the Director of Medicolegal Investigations, are a part-time Forensic Odontologist (dentist) and Forensic Anthropologist.

The Chief Medical Examiner, Dr. Mark Flomenbaum, is presently on paid suspension.

The Medicolegal Investigative Staff (MLIs) consist of a Director and three (3) investigators. Also reporting to, and organizationally under the MLI director, is the Administrative Staff.

The Technical Staff, referred to as "Morgue Techs", assist the Medical Examiners in preparing for and conducting autopsies. The Morgue Techs also have primary responsibility for processing the necessary paperwork to accept and release bodies. In limited cases, the Morgue Techs also transport bodies from the scene of death to the OCME.

The OCME also has non-medical management staff, consisting of a Chief Administrative Officer, a part-time General Counsel and a Human Resources Director, as well as a technology information officer, a three person fiscal unit and a facilities director.

The OCME also has satellite facilities in Holyoke and Worcester.

For a current Organizational Chart for the Office of the Chief Medical Examiner, please refer to **Attachment A**.

III. Scope of Review

Vance was tasked with reviewing the effectiveness of the managerial and administrative functions of the OCME. Specifically, Vance was asked to:

- ⇨ Assess the current managerial and administrative operations;
- ⇨ Determine if the managerial and administrative processes, measurements and practices conform to established best practices for similar systems; and
- ⇨ Report on findings and recommendations.

IV. Methodology

The Vance team approached its review of the OCME by employing investigative methods that elicit the most comprehensive understanding of the current operational processes, including:

- Interviews of all OCME staff members
- Interviews of key stakeholders
- Interviews of outside vendors
- Review of internal and certain relevant external documents
- Comparison/contrast with medical examiners and coroners in other states for best industry practices
- Establishment of a confidential "hotline"

For additional details concerning the methodology employed by the Vance team, please refer to **Attachment B.**

The Vance team which conducted this assessment and review consisted of the following core team:

- Robert N. Sikellis (Project Leader)
- Robert Delahunt
- Robert W. Knapp

In addition, a number of other Vance and non-Vance employees were tasked with specific assignments during the course of this review.

V. Summary of Recommendations

Vance's evaluation of the managerial and administrative functions of the OCME has yielded a number of findings and recommendations. Our recommendations seek to:

- **Reorganize the OCME management structure** to improve oversight and supervision as well as accountability, communication, and the overall expertise and knowledge base of the OCME.
- **Establish written policies and procedures and standard operating procedures** to ensure adherence to sound "best practices".
- **Establish and implement training programs in a number of critical areas.**
- **Evaluate certain practices and programs.**

Vance's Recommendations include:

- **Reorganize and implement effective management structure**
- **Develop infrastructure to support objectives**
- **Establish and conduct training programs**
- **Establish and implement written policies and procedures**
- **Invite NAME to conduct an inspection**

VI. Findings and Recommendations

1. There must be established at the OCME a robust chief operating officer position to provide needed management and oversight over all non-medical functions

The problems at the OCME described in this review are largely, though not entirely, the result of poor supervision and management practices on the part of the Chief Medical Examiner.

There should be appointed a Chief Operating Officer (COO) with significant management experience to oversee and manage *all* non-medical functions of the OCME. See **Attachment C** for a Proposed Organizational Chart. The Commission on Medicolegal Investigations ("Commission") should have the responsibility of identifying and recommending an appropriate COO, similar to their role in the hiring process for the Chief Medical Examiner.

Without infringing on the Chief Medical Examiner's necessary oversight of specific medical functions and decisions, the COO should have responsibility for overseeing and managing all operational aspects of the OCME. This would include, but not be limited to:

- **Budget**
- **Administrative functions**
- **Supervision (including hiring and firing) of non-medical staff**
- **Procurement**
- **Vendor contracts and relations**
- **Policies and procedures**
- **Facilities**
- **Training**
- **Safety and Security**
- **Information technology**

The COO would work with the Chief Medical Examiner in the overall operational design and implementation of services consistent with the office's statutory obligations, something that the OCME presently lacks.

For example, in one critical area discussed in detail in later recommendations, the COO, working with the Chief Medical Examiner, would be responsible for establishing standard operating procedures and policies for the OCME, in accordance with national best practices. Once established, the COO would be responsible for their implementation through staff training programs for orientation to these policies. An additional COO responsibility in this area would be ensuring that these policies are regularly reviewed and updated, and that the staff is advised of these updates.

The COO position recommended here is in sharp contrast to the present Chief Administrative Officer (CAO) position at the OCME, which has neither the strength nor independence contemplated. While in theory a CAO may be responsible for some of the functions discussed above, in reality at the OCME the CAO assists in executing day-to-day, ground level operations and addressing immediate problems and needs.

The concept proposed here is not foreign to medicolegal investigations. Numerous other jurisdictions, recognizing that there are many important non-medical managerial functions to a Medical Examiners/Coroners office that require the experience of a trained manager, have adopted some form of the model we are recommending here. Although we do not suggest that NAME necessarily would approve of this model, support for this recommendation can be found as far back as their inspection of the OCME in 2000. In that report, NAME noted:

> "Some thought must be given to the development of better administrative support to the Chief Medical Examiner. It is clear that the many budgetary and quality assurance aspects of the office take away from the time needed to provide oversight of medical investigations. *The Chief Medical Examiner should be a physician doing medical work. Someone…should be hired to oversee [the] operational needs".* (Emphasis added)

We fully recognize that Chapter 38 of the General Laws of the Commonwealth of Massachusetts vests supervision of the OCME with the Chief Medical Examiner. Specifically, that section, which established the OCME, provides that the OCME shall be "under the supervision and control" of the Chief Medical Examiner. Nothing we are recommending here should be viewed as depriving the Chief Medical Examiner of the type of authority the legislature intended when drafting the section. All medical functions of the office will continue to be supervised and controlled by the Chief Medical Examiner.

2. The COO must be empowered with independent authority and responsibility

The current problems of the OCME, discussed in greater detail below, stem in large part from the fact that exclusive authority for management and supervision was in the hands of a very capable forensic pathologist with no management experience. Rather than rely on the existing management team, however, the Chief Medical Examiner chose to largely ignore them and delegate many of his managerial and supervisory responsibilities to the Director of Medicolegal Investigations. This Director, installed by the Chief Medical Examiner, is himself inexperienced and untrained in management functions.

An obvious solution to this very unique problem is to select a Chief Medical Examiner who either has significant management experience or who recognizes and accepts the need for, and authority of, a strong operations chief. However, given the current condition of the OCME, the amount of work which needs to be done, and the critical need to implement sweeping changes to the administration and operation of the agency, we recommend that, at least until the agency has recovered, the COO have substantial authority.

Specifically, the COO must have independent authority and be held accountable for the supervision and management of the OCME along with – and to the same extent as - the Chief Medical Examiner. Critical to the success of the COO, and of this model, is a level of independent authority on the part of the COO. Even the best manager will be ineffective when stripped of much of his or her authority or largely marginalized. For the recommended model to be successful, the authority of the COO here must not be dependent on or derived from the Chief Medical Examiner. While the COO should report to the Chief Medical Examiner to assure uniformity of priorities, the COO should have independent authority derived from (and responsibility to) the Executive Office of Public Safety, through the Undersecretary for Forensic Sciences.

Medical examiners and coroners across the country vary dramatically in how they are organized for this purpose. Three jurisdictions are instructive, though we do not suggest comparable: Virginia, New Jersey and Los Angeles.

In the Commonwealth of Virginia, the Chief Medical Examiner's Office has a strong Chief Operations Officer responsible for all non-medical functions. While the COO has substantial authority, she reports to the Chief Medical Examiner.

In New Jersey, the Chief Medical Examiner's office has a Business Manager position that is similar to the proposed COO position here. This Business Manager reports to the state Division of Criminal Justice Chief of Staff, not the Chief Medical Examiner, which has direct oversight of the Medical Examiner's Office. The Division of Criminal Justice, in turn, reports to the state Attorney General.

The County of Los Angeles is similar to New Jersey in reporting structure, although it is a coroner-based system as opposed to a medical examiners system. As a result of a series of high profile scandals, the office was essentially split in two. The Coroner and his medical staff exercise only the statutory authority of establishing cause and manner of death. All other functions are managed by a Director. Both the Coroner and the Director report individually to an elected Board of Supervisors.

3. The Executive Office of Public Safety must act in an oversight capacity and work with the Chief Medical Examiner and the Commission to ensure effective delivery of services

The position of Undersecretary for Forensic Sciences ("Undersecretary") was intended to provide oversight of all forensic services in the Commonwealth of Massachusetts, including, among others, the OCME. The intention was to have one secretariat/executive level individual coordinating and overseeing all forensic functions and activities. Chapter 6A, section 18½ of the General Laws for the Commonwealth of Massachusetts establishes the Undersecretary position and provides that the Undersecretary "shall oversee the functions and administration" of the OCME. .

Here, however, the relationship between the Undersecretary and the Chief Medical Examiner deteriorated, impacting the administration of the OCME. This was in part due to the position of the Chief Medical Examiner, a position held by many medical examiners nationally as well as by NAME, that medical examiners must be wholly independent of law enforcement in executing their duties.

Without addressing the political question of where in the overall state organizational hierarchy the OCME should be placed, by statute in the Commonwealth the Undersecretary and the Chief Medical Examiner are necessary partners in establishing and administering a comprehensive and effective system for the delivery of medicolegal death investigations. Nationally, this is not an uncommon model. Of the states with a state-wide medical examiners system, like the Commonwealth's, Maine, New Hampshire and Oregon are comparably organized. Of the states with a decentralized system, Georgia and Montana have similarly hierarchically organized. Please refer to **Attachment D** for a full discussion.

The Undersecretary must continue to have a central role in overseeing the OCME and in particular the progress of this reformed organizational structure at the OCME. The Undersecretary must work closely with the Chief Medical Examiner and the COO in implementing the reforms proposed in this report, as well as any subsequent

recommendations proposed by NAME. Additionally, the Undersecretary must also work closely with the Commission

While the Undersecretary role is not one of day-to-day operational management of the OCME, strong oversight is a key component of the reformed structure of the OCME, and the Undersecretary (along with the Commission on Medicolegal Investigations discussed below) is primarily charged with this responsibility.

4. The Commission on Medicolegal Investigations should be revitalized and play a central role in the rehabilitation of the OCME

The Commission was established by Chapter 6, section 184 of the General Laws for the Commonwealth of Massachusetts. Its important purpose is to serve as an advisory and oversight board for the OCME. The Commission is also charged with responsibility for reviewing and approving the comprehensive system for the delivery of medicolegal services adopted by the Chief Medical Examiner.

The Commission has not met since October of 2006. Its members' terms have since expired.

Under the statute, the Governor appoints 13 people of distinct backgrounds to sit on the Commission. Additionally, the Attorney General and the Secretaries of Public Safety and Public Health, or their designees, also sit on the Commission. Each member chosen by the Governor is to serve a three year term or until his successor is appointed. Please refer to **Attachment E**.

The Commission must be revitalized. Its statutory power is substantial and it can and should play a central role in the stabilization and growth of the OCME. It is critical to the rehabilitation and growth of the OCME, and the implementation of these recommendations to enlist the assistance and support of the members of the Commission.

One of the first responsibilities of the Commission should be to work with the Executive Office of Public Safety in the selection of a properly qualified COO for the OCME. Other areas of involvement include, but are not limited to:

- Assisting with securing additional funding,
- Advocating for necessary legislation,
- Reviewing and approving major policy decisions, and
- Generally advising the OCME on issues relevant to the rehabilitation.

The Commission must also meet and assess progress in implementing these and any subsequent recommendations put forward by the National Association of Medical Examiners to rehabilitate the OCME.

A revitalized Commission actively fulfilling its intended role is critical to the success of the OCME.

5. The OCME should immediately establish policies and procedures and/or standard operating procedures for all critical functions

The OCME, alone amongst every other comparable jurisdiction and contrary to standards established by the National Association of Medical Examiners ("NAME") and national best practices, lacks written policies and procedures and/or standard operating procedures ("policies") in virtually all areas, from its most basic to its most critical functions. Working with the CME, establishing and implementing appropriate policies must be one of the principle priorities of the COO.

Among the areas that require formal policies and procedures:

- **Body intakes/releases**
- **Forensic autopsy standards**
- **Quality control/quality assurance**
- **Identification Procedures**
- **Jurisdiction of cases**
- **Handling of Bodies and Evidence**

Critical areas lacking written policies which must be implemented immediately include, but are not limited to, the following:

Body Intakes and Releases

It borders on the incredible that the intake and release of *human remains* (and personal effects) from a government agency is governed by a verbal understanding of the process by OCME personnel. That all releases are actually handled by the Morgue Technicians who, as noted later in this report, while hardworking are largely untrained and unsupervised, makes the lack of written policies that much more troubling. Adding to the concern is that a casual visitor need only spend a short time in the "receiving area" of the OCME (located in the back of the building, through which all bodies are received and released from the OCME) to experience the chaos of activity and understand why one employee noted in their interview, "it is amazing that we have not lost more bodies."

The OCME's Chief Administrative Officer, at the request of the Executive Office of Public Safety and following the incident involving the missing body of Thomas Brissette, prepared a draft policy governing the intake and release of human remains. That policy is still in draft form and has not been implemented. It should be implemented immediately. Please refer to **Attachment F** for two additional policies governing the release of human remains, the first provided by the Los Angeles County Department of the Coroner and the second by the Chief Medical Examiners Office, State of New Jersey.

Forensic Autopsy Standards

There are presently no written policies or standards governing autopsies or addressing the professional aspects of individual death investigations. Such policies must be drafted and implemented immediately.

For the Forensic Autopsy Performance Standards promulgated by the National Association of Medical Examiners, please refer to **Attachment G**.

Quality Control / Quality Assurance

There are presently no written standards establishing a quality control and assurance program. This is a serious deficiency. Such written standards cannot be ignored in such a vital function as that being performed by the OCME, and in light of the critical nature and use of the forensic findings developed by the Office.

The Chief Medical Examiner has instituted daily (each afternoon except for Wednesdays) conferences with the Medical Examiners during which they discuss the autopsies performed that day, including any unusual or difficult issues they presented. The Medical Examiners share their thoughts concerning these issues during these meetings, and discuss as a group the manner in which they believe such issues should be resolved. This is arguably a form of quality assurance. The Chief Medical Examiner was successful in qualifying these daily case conferences for continuing medical education credit.

Best practices, however, call for more. The OCME should establish a quality control and quality assurance program. At a minimum, this program should include the periodic review of select cases.

For a Sample Forensic Autopsy Quality Improvement Program, please refer to **Attachment H**.

Identification Procedures

Basic requirements for the identification prior to the release of unclaimed or unidentified bodies are contained in 505 CMR 2.00. However, there is no OCME policy outlining the

specific identification procedures to be followed. Confusion over what standard should be applied to identifying decedents is one reason for the "body backlog" which took place at the OCME this past spring.

For sample Standard Identification Procedures, please refer to **Attachment F**.

Jurisdiction of Cases

While this is governed by statute, in a majority of the cases the statute vests a great deal of discretion in the Chief Medical Examiner to accept jurisdiction. Given that each Medical Examiner and most MLI investigators in the OCME participates in the intake process (described later in this report), a written policy must be developed to guide the Medical Examiners in the exercise of this discretion. This is particularly true for the OCME, where there appears to be a difference of opinion on the part of the Medical Examiners on the types of cases (outside the mandated cases) the OCME should accept.

Body Transportation / Handling and Evidence Handling/ Storage

As discussed in more detail in a later recommendation, the OCME does not have a written policy relative to body transportation and handling.

A policy outlining a body transport system that reflects due respect for the decedent, concerns for the families, and preservation of evidence/personal effects must be implemented immediately. The District Attorneys and the Executive Office of Public Safety should work with the OCME to develop a policy that addresses issues of chain of custody and preservation of evidence in those cases likely to lead to criminal charges.

Additionally, the OCME also lacks policies in the following critical areas:

- **Evidence collection**
- **Post mortem examination procedures**
- **Facility maintenance**
- **Facility security**
- **Safety issues**
- **Personnel issues (including procedures for discipline and removal for cause)**
- **Qualifications for medical investigators**
- **Criteria for determining when complete autopsies, partial autopsies, or external examinations are to be performed**
- **Retention and disposition of organ and tissue specimens taken at autopsy**
- **Evidence and specimen disposition and destruction**

- **Tissue and body fluid specimen collection**
- **Collection of toxicology specimens**
- **Reports and records keeping**
- **Distribution of records and information**
- **Organ and tissue donation**

Written and implemented policies or standard operating procedures covering the above areas are essential. They are not only consistent with national best practices, but are required for NAME accreditation. Under NAME's standards, a lack of a policy in any of the above areas would constitute a "Phase II" deficiency for accreditation purposes. Pursuant to NAME's standards, Phase II standards "are considered essential requirements; any [Phase II deficiency] may seriously impact the work or adversely affect the health and safety of the public or agency staff." See *Inspection & Accreditation Policies and Procedures Manual*, National Association of Medical Examiners (September 2003) p.1. A single Phase II deficiency would result in denial of accreditation.

Establishing and implementing written policies in at least the areas outlined above must be a priority.

6. The OCME should immediately establish policies and procedures and/or standard operating procedures for a variety of other important functions

In addition to the policies listed above which are necessary for NAME accreditation and consistent with national best practices, the OCME should also establish policies in the following areas that are necessary for the proper functioning of the agency.

Reconciliation of Bodies

This basic function has been almost completely neglected. There is no policy, written or otherwise, requiring the reconciliation of bodies in the OCME. The OCME must immediately establish a written policy formalizing the frequency and manner of "cooler" (body storage location) checks as well as frequent reconciliation and inventory, which is not regularly done (to date, such a reconciliation was done a few times following the OCME's recent misplacement of a body, then abandoned.)

There is a simple process which should be employed for this reconciliation. The OCME utilizes what is known as a "LIMS" (Laboratory Information Management System)

system. Implemented in 2004, LIMS is a bar coding, evidence tracking and inventory management system. Every body, upon arrival to the OCME, is required to be "LIMSed in" to the system. Upon release, it is "LIMSed out" of the system.

A procedure should be established requiring that an "inventory" printout from the LIMS system be physically reconciled and checked against the bodies in the cooler. This should be done at least twice a week, if not more frequently.

Incident Reporting System

There is presently no incident reporting system or policy at the OCME. Such a system, designed to require employees to report unusual incidents, should be established. Had there been such a requirement, it would have assisted in an earlier reporting of the recently misplaced body, which went days before being reported to management.

There exists an outdated 2003 Policies and Procedures Manual which had been compiled by Richard J. Evans, M.D., the OCME's previous Chief Medical Examiner. Most staff members we spoke with were unaware of its existence and these policies had not been endorsed by the new Chief Medical Examiner. Likewise, there is no indication staff were referencing or relying on this old manual.

7. The OCME should immediately implement a mass disaster/fatality response plan and conduct preparatory staff training

The OCME has a largely outdated mass fatality response plan which is in draft form. The draft plan is undated but is pre-2004. There is no indication that staff members are aware of its existence and no staff members have been trained in accordance with the plan. Likewise, there is a *Disaster Response Plan for Unconventional Fatalities: Chemical-Radiological-Nuclear-Biological-Explosive*, prepared in February of 2004 by Richard J. Evans, MD, the former Chief Medical Examiner. There is no indication that staff members are aware of its existence and no staff members have been trained in accordance with this plan either.

While some OCME staff members have attended some mass disaster state and federal sponsored trainings, the approach has been largely uncoordinated and haphazard.

The OCME would not have the ability to respond in a coordinated and effective fashion in the event of a mass disaster in the Commonwealth of Massachusetts.

Mass disaster/fatality planning must become a priority for the OCME and, in accordance with national best practices, a Mass Fatality Plan must be implemented. The plan should also include consideration of conventional and unconventional weapons of mass destruction, protective clothing and equipment, body handling and decontamination issues, etc. The plan must be developed in coordination with law enforcement, health care providers and other public health and safety agencies. Consideration should be given to coordinating with surrounding jurisdictions, as medical examiners from other jurisdictions have done. A Vance security expert who reviewed the old plans prepared by Dr. Evans concluded that, while outdated, they could properly form the framework for updated plans.

The OCME staff must be trained in the plan and be aware of their duties and responsibilities in the event of a mass fatality. A more coordinated effort must be made for OCME staff to participate in local, regional and federally sponsored mass disaster exercises.

For a Sample Mass Fatality Plan, please refer to **Attachment I**.

Additionally, best practices also dictates the preparation of a Continuity of Operations Plan, which the OCME does have, drafted in April of 2007. OCME staff must be trained in accordance with this plan.

8. Promulgation of important OCME policies and plans should receive adequate review before implementation

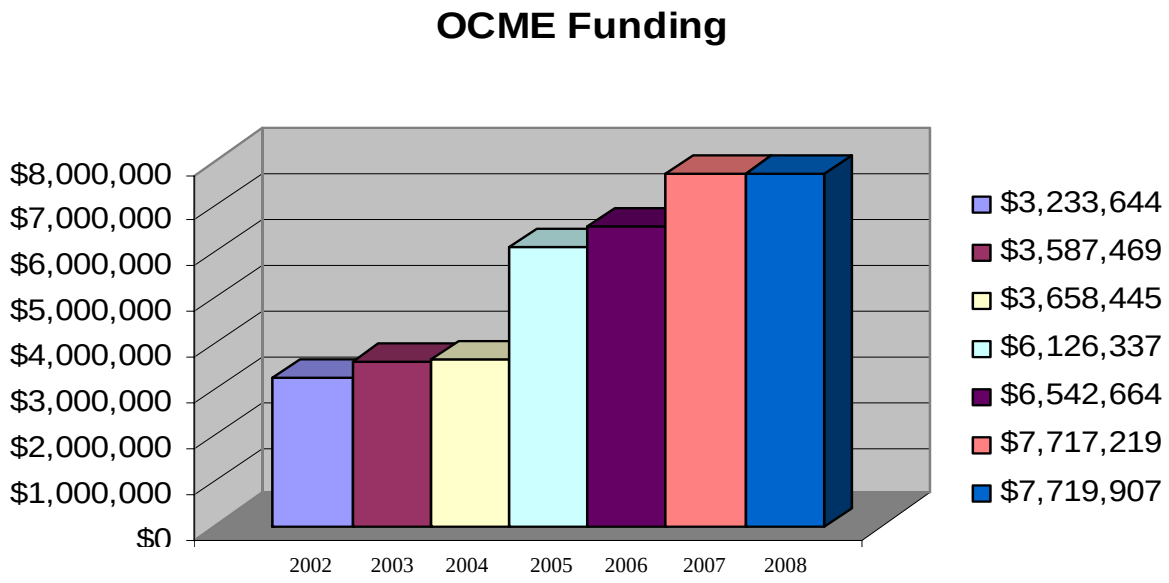
Prior to promulgation and implementation of the policies outlined above, significant policies and procedures, as well as the mass disaster/fatality response plan, should undergo adequate review by both internal and external groups. The Commission on Medicolegal Investigations ("CMI") should play a central role in reviewing many of these more important policies, as should, where appropriate, the Executive Office of Public Safety. Additionally, relevant stakeholders who would have a direct interest in a major policy area should be consulted in advance of formal implementation of policies.

This will not only increase effectiveness of the policies, but vest the stakeholders as well. The goal of this policy creation/updating process is to improve performance in all aspects of the OCME operations. This can best be accomplished with input from relevant stakeholders.

9. Funding for the OCME should be increased

There have been recent steady and significant increases to the OCME's operating budget and capital funding. For the first 20 years of its existence, the OCME found itself chronically under-funded and struggling to meet its mission. Following this prolonged period of low and basically level funding in the range of $3,000,000, in 2005 funding for the OCME was significantly increased from the previous year. Since that time, funding levels have steadily but not markedly increased.

Based on information supplied by the OCME and the Executive Office of Public Safety, the operating budget for the OCME for the past 7 fiscal years has been as follows:



While significant progress has been made, the office remains below the national average when viewed from a cost per capita standpoint, the generally accepted standard in the industry, as well as below NAME recommended funding. Further, while there have been these recent increases, the OCME had been chronically under funded for many years.

While better operational management will likely lead to some savings, these savings will not come close to getting the OCME to a funding level on par with the national average or that recommended by NAME. Increased funding will be necessary to implement some of the recommendations, particularly the establishment of the various positions, contained in this report. It will require the continued advocacy of all stakeholders to accomplish this necessary increase.

10. A Deputy Chief Medical Examiner should be hired or appointed from the existing Medical Examiners

The Chief Medical Examiner has not appointed a Deputy Chief Medical Examiner.

The appointment of a Deputy Chief Medical Examiner is required by G.L. c. 38, section 2, by sound management principles, and by national best practices. Sound business practices dictate the establishment of a Deputy Chief Medical Examiner to assist with oversight and supervision of certain critical medical functions or to take charge in the Chief Medical Examiner's incapacity or absence. Moreover, hiring a Deputy Medical Examiner is vital to the successful implementation of the recommendations contained in this report.

11. The OCME must increase internal communication and conduct orientation for new staff

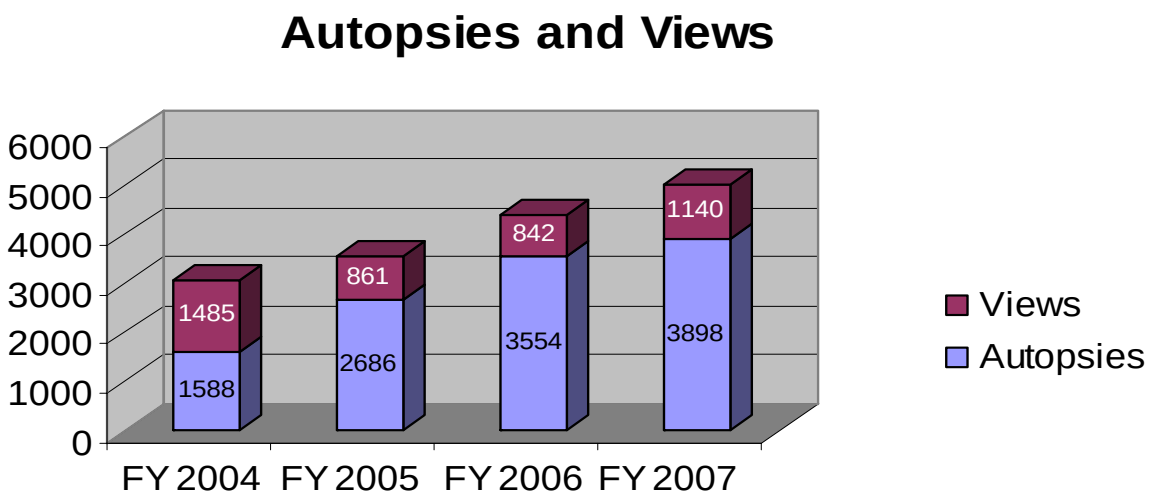
The OCME functions as multiple "silos" with little communication among the various practice areas. This has contributed to an almost complete lack of unity of purpose, low morale, and what can properly be characterized as the beginnings of a culture of indifference. Efforts must be undertaken to integrate the various office functions.

The OCME must utilize a number of vehicles, including policies and procedures, staff orientation and staff training to fully integrate all personnel with not only a better understanding of their specific roles, but the roles of those around them as well. Among other things, this will make operations more effective and efficient, and will reduce the potential for serious errors. Linking staff by a common understanding of roles and common purpose should be achieved.

12. The OCME should evaluate the number of autopsies it is presently performing

The number of autopsies being performed at the OCME has increased significantly over the past three years. While the law mandates that the Chief Medical Examiner accept jurisdiction in certain cases, there is otherwise discretion in accepting jurisdiction. Likewise, the statute vests him with discretion in deciding which cases to autopsy (as opposed to view) once jurisdiction is accepted.

The following graph contains statistical information furnished by the OCME:



A "view" is an external examination of a body, as opposed to a full autopsy.

There are a number of aspects of this increased casework which must be evaluated.

First, this discretionary increase in casework requires the current medical examiners to perform autopsies far exceeding NAME accreditation standards and national best practices standards.

A Phase I deficiency exists under NAME standards if an office requires its autopsy physicians to perform more than 250 autopsies per year per physician. A Phase II deficiency exists if an office requires its autopsy physicians to perform more than 325 autopsies per year per physician. Additionally, under NAME standards, three to five "views" (external examinations) are considered equivalent to one complete autopsy. As

noted, a Phase II deficiency, according to NAME, may seriously impact the work or adversely affect the health and safety of the public or agency staff.

The Chief Medical Examiner was not performing autopsies, leaving 11 physicians on staff who were performing autopsies and conducting views. If all 11 medical examiners had been on staff for the past 2 years and working full time, neither of which was actually the case, the number of autopsies per physician per year at the OCME far exceeds any acceptable standard.

NAME Standards	OCME PERFORMANCE	
	FY 2006 – 338 autopsies per physician (including views)	FY 2007 – 375 autopsies per physician (including views)
Phase I Deficiency >250 autopsies per physician per year	**Exceeds by 35%**	**Exceeds by 50%**
Phase II Deficiency >325 autopsies per physician per year	**Exceeds by 4%**	**Exceeds by 15%**

Second, as is evident from other parts of this report, there is little supporting infrastructure in place at the OCME. While there has been an increase in the number of physicians, the increase has not offset the increased casework. Additionally, the increased casework does not only affect the physicians, but the entire system (Morgue Technicians, investigators, administrative staff, toxicology testing, etc.). In fact, toward the end of FY 2007, the OCME was forced to cut back significantly on toxicology testing when it became clear they were going to run out of money. The OCME is simply not prepared to effectively handle such an increase in the caseload.

Third, this discretionary increase in casework has necessitated that far more of the actual autopsies be performed by the Morgue Technicians. The amount of work Morgue Technicians typically perform during an autopsy varies by jurisdiction. Some jurisdictions allow for a large part of the autopsy to be performed by a morgue technician, others limit them to only assisting the physicians. This is based largely on office policy and the training and experience level of the technicians.

At the OCME, the Morgue Technicians are performing a large part of the autopsy in many instances so that the office may keep up with the casework. No other jurisdiction appears to have Morgue Technicians involved to the degree they are at the OCME, particularly given that at the OCME they operate without the benefit of some forensic training (all their experience is gained “on the job”), or pursuant to existing written policies and procedures.

We fully recognize the public health value in determining cause and manner of death in cases other than those likely to result in criminal charges, and much important work has been done in this area by medical examiners/coroners across the country. However, increasing the casework to the degree done here on an already severely stressed, if not broken, system does not advance these goals. Nor does it assure the ability to fulfill the core function of the OCME. While exceptionally qualified new forensic pathologists were also added to the staff of the OCME during this time, the new hires did not offset the increased casework.

We stress that it is not our intent to impose our non-medical judgment in place of the amply qualified medical judgment of the Chief Medical Examiner with respect to which cases should be accepted by the OCME. Our recommendation is that from a management perspective, increasing the case work under the conditions that exist at the OCME must be re-evaluated.

The OCME should consider scaling back the number of autopsies it is performing until it can build the necessary infrastructure to support the work and obtain funding to hire additional physicians and support staff to bring the OCME in compliance with NAME and national standards.

13. The OCME should immediately implement a health and safety program for employees and visitors and appoint or hire a safety officer

Lack of basic health and safety considerations was a recurrent theme during our interviews at the OCME. Health and safety issues were also independently observed and identified as a serious concern by the Vance team.

The OCME must immediately focus on developing a program aimed at the health and safety of its staff and visitors. This program must have both an educational and enforcement component.

This program should include all OCME staff. Particular emphasis should be directed to the Morgue Technicians, almost all of whom work in the OCME's autopsy suite assisting with autopsies and have an increased risk of biohazard or chemical exposure without the benefit of anything more than "on the job" health and safety training. Necessary safety warnings should be posted to protect visitors and remind staff.

The program should focus on addressing safety issues and comport to federal and state regulations with regard to injury and illness prevention. It should include a blood-borne

pathogen control program, offer staff appropriate vaccinations and outline the procedures for facility evacuation in the event of an emergency.

The OCME recently advised the Vance review team that it is now in the process of seeking to hire a "Safety Officer." This is a positive development which must be followed through. This person, when hired, needs to not only implement a training/education program for OCME staff and assist in drafting policies aimed at protecting the staff and visitors, but also be empowered to enforce health and safety violations at the OCME. Such a program, coupled with an enforcement component, should address some of the concerns associated with the OCME's rate of industrial accidents.

If the OCME cannot develop such a program internally, it should identify area health institutions where such programs are being offered and arrange for OCME employees to attend.

14. The OCME should immediately increase security at the Boston headquarters and implement a security awareness program

There is very little physical security in place at the OCME headquarters in Boston and, as noted, no policy covering facility security, written or otherwise. While the main entrance in the front of the building requires that visitors be buzzed in by a receptionist, the main receiving area to the rear of the building was (until recently suggested otherwise) effectively open to whoever wished to enter. As noted in other parts of this report, the area is frequently very chaotic, with OCME staff and funeral home/livery service personnel freely and openly coming and going. Even the most basic security measures, such as requiring staff to display identification cards which they have been issued, are absent.

Security at the OCME must be increased and include controlled access to the entire facility. There must be increased recognition that much of the work being performed at the OCME requires evidence integrity considerations. Access to the body receiving area and handling area must be limited and controlled. The OCME may want to consider limiting funeral home pickups to certain hours a day.

Additionally, the OCME must address security concerns with a large new "cooler" that is being built in the outdoor back lot of the OCME, where additional bodies will be stored. Space limitations did not allow for the cooler to be placed inside the existing OCME facility.

Once a security awareness program and security policies are established, the OCME must educate its personnel accordingly.

While there are Massachusetts State Police Officers from the Crime Scene Services section stationed at the OCME, they cannot be regarded as security personnel for the site, as was argued in the OCME's response to the NAME inspection in 2000. Facility security is not their function, of course, and they are often away from the OCME responding to crime scenes.

15. The OCME should evaluate the process by which it handles "removals"

"Removals" refers to the transportation of bodies from the scene of death to the OCME in cases where the OCME has exercised jurisdiction. Presently, the OCME contracts with private funeral homes and livery services to handle the majority of their removals. In a very small number of cases, the Morgue Technicians handle the removals. This process has not been formally evaluated.

A cost-benefit analysis must be performed to determine whether continuing this practice is in the best interest of the OCME. Consideration should be given to a number of factors in this analysis.

First, information furnished by the OCME showed that the OCME spent nearly $700,000 of its appropriated funds during FY 2007 on such removals.

Second, the OCME owns and maintains a fleet of 11 vehicles most of which are equipped to handle removals.

The OCME must conduct a cost-benefit analysis to determine whether outsourcing of this function is fiscally sound. In this analysis, consideration should also be given to the issues raised in the following recommendation, as well as the administrative costs associated with managing an outsourced removal process.

The alternative to outsourcing this function would be to use the funds to hire more Morgue Technicians who could handle most if not all of the removals while also supporting the OCME in other functions.

16. The OCME should professionalize and build in controls if it will continue to outsource "removals"

If after a formal cost-benefit analysis is conducted the decision is reached to continue utilizing private funeral homes and livery services to handle removals, the process employed for such removals must be changed.

The current contracts in place between the OCME and the various funeral homes and livery services which provide removal services to the OCME are simple and standard contracts. They contain only the following description of contract performance: "Provide decedent transportation and removal services for the Office of the Chief Medical Examiner (OCME)."

In May of 2007, a new solicitation for "decedent transport and removal services" was put out to bid by the OCME. Please refer to **Attachment J**. The terms of the contract under the new solicitation are a significant improvement over the existing version, as they will now require, among other things, certification of licensure by the Board of Funeral Homes and Embalmers, criminal background checks of personnel who will be performing the removals and performance within one hour of notification if possible.

These improvements, however, still fall below best practices and national standards. The body transport system employed by the OCME, largely viewed as just a contractual relationship for services, fails to take into consideration a host of important factors.

The contracts must contain body handling procedures signed by all parties that reflect due consideration for the decedent and concerns of the family. Written agreements signed by the OCME and the funeral homes and livery services they utilize should be put in place containing, among other things, a code of conduct provision and standard operating procedures to be employed when transporting a body.

Importantly, the District Attorneys should be consulted to assist with developing body handling procedures in potential criminal cases (although the procedures should be used in all cases) that ensures the integrity of evidence. Sealed body bags (required by NAME accreditation standards) or other similarly effective means should be considered, as should a system that documents the acquisition and custody of the decedent's personal effects.

This is not to suggest any concern about the professionalism on the part of the funeral homes, who are more than accustomed to ensuring integrity and respect for human remains. It is simply consistent with best practices that families and decedents deserve such consideration from the OCME, and the courts in criminal matters may require it.

17. The Medicolegal Investigative Program should be refocused to directly support the Medical Examiners

The Medicolegal Investigative (MLI) Program is not and has never functioned as an MLI program is intended to function. A properly constituted and functioning MLI program responds to death scenes and conducts investigations as the "eyes and ears" of the OCME.

This program failed from its inception in part due to a lack of funding to fully staff the program and in part due to the manner in which the program was implemented.

The three investigators are not certified by the American Board of Medicolegal Death Investigators, as required for NAME accreditation. In fact, notwithstanding statements to the contrary by the Director of the MLI program at the OCME, these investigators received little or no relevant training prior to or during their tenure with the OCME, other than "hands on" work under the direction of the Director.

The Director of the program almost immediately alienated virtually every law enforcement official he came in contact with – necessary partners in death investigations - and virtually assured the program's failure almost before its formation.

All of this was or should have been known very soon following the inception of the program. Yet rather than attempt to repair or reevaluate the program, it has been allowed to flounder with no apparent focus. In the interim, the program's Director has been given greater responsibilities to the point where he, along with the Chief Medical Examiner, run the OCME, notwithstanding that neither possesses any managerial or administrative experience.

The program is and has remained unfocused and it is not clear what contributions its Director or his staff are, or have been, making for the OCME. This program needs to be refocused.

Implemented correctly, an MLI program serves an important function in death investigations. An effective and well run MLI program is not only consistent with national best practices, but a prerequisite to NAME accreditation.

Unless and until the program can be properly organized, implemented, supervised and funded, the MLI staff, including the Director, should be reorganized as forensic investigators to serve a more critical and immediate need: direct support of the Medical Examiners. The physicians at the OCME often themselves take time from autopsy work and report writing to attempt to collect basic important information they need for their cases. Such information includes, among other things, the decedent's past medical history and current treatment records, emergency medical treatment records, and police

reports in order to ascertain the essential facts and circumstances of death. The Medical Examiners need immediate access to such information to both decide whether an autopsy (as opposed to a "view") is warranted and to close out cases and finalize reports.

While one of the present responsibilities of the MLI staff appears to be such a support role, they are not answerable to the medical staff and their tasks, dictated by the Director of that program, are often not consistent with the immediate needs of the Medical Examiners. The MLIs/forensic investigators should report directly to a Medical Examiner (absent a Deputy Chief Medical Examiner), who should assign them to support the other Medical Examiners as needed.

18. The OCME should evaluate the manner in which it handles toxicology testing

The OCME currently outsources toxicology testing to the UMASS Medical Center in Worcester. Law enforcement officials have voiced concern over delays in obtaining results, the inability to prioritize cases and uncertainty as to the exact nature of the process. An audit of this system must be undertaken to determine if this is the most efficient manner to obtain toxicology tests.

Similarly, consideration of the extent of toxicology testing necessary for each case must also be evaluated. The OCME has had a policy to order the most extensive testing possible in all cases, without consideration of need, possibly unnecessarily increasing cost and processing time.

19. The OCME should implement necessary information technology system upgrades and properly train its staff

Several problems exist with the current information technology system at the OCME. The IT system consists of, among other things, two primary computer programs for purposes of organization and case management: 4NSys, the case management system, and LIMS, which is used as a database to track evidence and inventory management.

In mid-2006, a review was conducted by a private IT consulting firm. Highlights of the issues identified with these systems include, among other things, the following:

- The 4NSys' data entry does not follow the work flow of the OCME. As a result, entries are often difficult to find or entered inconsistently.

- 4NSys does not allow for audit tracking capabilities, capture of information regarding toxicology or other special studies, or the completion of Death Certificates

- Certain data must be entered multiple times on different screens on each computer system, leading to inefficiencies.

- Neither the 4NSys nor the LIMS systems integrate well with one another.

- The Holyoke and Boston offices have different systems which do not share information.

- There is no adequate backup being performed with regard to data and the minimal backup data is not stored at an offsite location.

- Inconsistent use of both systems renders the programs even more unreliable. As a result, data quality and integrity is low and the systems' use is inefficient, cumbersome and unstable.

- There exists confusion as to communications between the office and other entities such as law enforcement and funeral homes. As a result, poor communication exists between the agencies, forcing outside agencies to call several times to get or give information, often having to start from the beginning each time because there is no record available of the previous conversations

- The staff has not been trained to use either system to its potential. As a result, the inadequate software is not even being used to its full capacity. The further result is that some information is entered manually in folders which are often difficult to locate and sometimes found and contaminated in the autopsy suite.

- The 9-year-old telephone system is antiquated and does not support several necessary requirements including, among other things, recording of calls, use of wireless devices (such as headsets), Caller ID and voice-over technology.

This same private firm issued a report containing several recommendations, which included:

- A new system-wide case management system (or the 4NSys adequately redesigned) that could be implemented in all offices for centralized case intake, tracking and reporting that could integrate well with the LIMS system. The program, among other things, should follow the general workflow of the OCME.

- Checklists should be completed before a body is released. There should be a universal procedure with the checklists as well as certain personnel trained to fill them out.

- All personnel should be adequately trained to work the new and (until a new system is implemented) standing IT equipment.

- Clear written procedures as to the IT equipment should be promulgated and used in the proper assigning of responsibilities to personnel.

- Non-digital documents, such as photographs, Death Certificates, etc., should be scanned into the system.

- Tape backups from the computer systems should be stored offsite.

- A complete chronology should be kept of all communications in connection to a case with law enforcement, funeral directors, family, etc.

- A new telephone system which can support necessary functions, some of which are listed above, should be used to replace the existing telephone system.

To date, none of the recommendations have been implemented, nor have any of the interim recommendations proposed been implemented. Funding must be obtained for the necessary IT upgrades.

20. The Forensic Odontologist and Forensic Anthropologist should report to either the Chief Medical Examiner or the Deputy Chief Medical Examiner

Recently, following a re-organization by the Chief Medical Examiner, the Forensic Anthropologist and Forensic Odontologist (dentist), both doctors, were placed under the supervision of the Director of the MLI Program, a physician's assistant by education.

Absent the appointment of a Deputy Chief Medical Examiner, all medical staff should be under the direct supervision of the Chief Medical Examiner.

Both the Forensic Anthropologist and Forensic Odontologist have limited interaction with the Director of the MLI Program, who has neither the education or training to properly supervise them, and the current reporting structure is demoralizing for these professionals. Most importantly, it has also resulted in little if any helpful oversight or supervision.

21. The OCME should establish a dedicated identification unit

The OCME does not have a dedicated identification unit to identify bodies which are badly decomposed or otherwise unidentifiable.

A dedicated identification unit should be established, comprised of the Forensic Anthropologist, the Forensic Odontologist and a forensic investigator(s), who should report to the Chief Medical Examiner or, when appointed, the Deputy Chief Medical Examiner. In addition to conducting the necessary investigations to establish identification, this unit should be responsible, subject to the Chief Medical Examiner's approval, for generating policies and procedures governing identifications. The unit should also provide benchmarks for what constitutes a sufficient level of information before a conclusive identification can be made, which is one issue that lead to the recent "backlog" of bodies.

22. The intake process at the OCME should be streamlined

"Intake" refers to the process by which the OCME is notified of a death which may be within its jurisdiction and the decision to accept or decline jurisdiction is made. There are effectively two separate intake systems in place at the OCME, depending on the time of death. From the hours of 3:00 p.m. until 10:00 a.m. weekdays and during all hours over weekends, intake personnel (specially assigned Administrative Services employees) receive the initial call and collect basic information (contained on a two page checklist, see **Attachment K)**. The on-call Medical Examiner is then notified and provided with the summary information. The Medical Examiner decides whether to accept or decline jurisdiction.

Over the last year, the Chief Medical Examiner assigned the MLIs the responsibility of "investigating" a potential case prior to the assigned Medical Examiner accepting/declining jurisdiction. The practical result of this has been that, between the hours of 10:00 a.m. until 3:00 p.m., the intake person, after collecting the basic summary information, then forwards the call to an MLI, who conducts an "investigation", largely consisting of obtaining the same summary information over again. Often, MLIs are not immediately available, resulting in delays.

The intake personnel at the OCME are amply qualified and quite professional. On balance, the MLI's have added nothing to the process but unnecessary delays. These delays have required officers to unnecessarily remain at scenes longer (in one recent incident, up to 3 hours). Importantly, it has of course also required decedents to remain at the scene, in many instances in homes with distraught family members or on public roadways in public view.

The MLIs should be removed from this process at least until more can be hired and properly trained to expeditiously handle intakes.

23. NAME should conduct an inspection of the OCME

The National Association of Medical Examiners (NAME) is the "gold standard" in the industry. NAME's inspection program is a peer review system. The goal of such inspections is to improve office or system performance through objective evaluation and constructive criticism. NAME's Inspectors are the medical examiner's peers and serves as guest consultants to the office or system.

NAME inspections focus on organizational structure, operational details and funding and compare them to a checklist for inspection and accreditation established by NAME as well as to other jurisdictions known to provide high quality forensic death investigations.

NAME last conducted an inspection of the OCME in October of 2000. At the time, at least fifty (50) Phase I deficiencies were found throughout the system, ranging from not regularly calibrating body or tissue scales to having insufficient medical staff so that physicians were required to perform more than the maximum recommended 250 autopsies per year. Accreditation will be denied if more than fifteen (15) Phase I deficiencies are found.

Additionally, during its 2000 inspection, NAME identified at least ten (10) Phase II deficiencies in the Boston office alone, ranging from the OCME not having written policies or standard operating procedures on many critical functions to not regularly verifying the decedent's medical and emergency treatment records. One (1) Phase II deficiency will result in accreditation being denied. At the time, NAME recommended, among many other things, that the OCME curtail a number of non-essential activities "until the numerous deficiencies can be corrected."

The OCME or EOPS should arrange for a NAME inspection of the OCME as soon as possible.

With this report and NAME's inspection report, the OCME and EOPS should have a clear understanding of the current state of the OCME. This should provide not only a benchmark against which future progress can be measured, but also a road map to move the OCME forward.

24. NAME Accreditation should be a long term goal

NAME accreditation should be the long-term goal for the OCME. Striving to achieve NAME accreditation would be one way to assure the long-term stability and professionalism of the OCME.

See **Attachment L** is a list of offices presently accredited by NAME. NAME accreditation lasts for 5 years.

25. The Administrative staff should report to the Chief Administrative Officer

As part of the Chief Medical Examiner's office reorganization referenced above, all Administrative Services personnel presently report to the Director of Medicolegal Investigations, notwithstanding that the OCME has a Chief Administrative Officer.

The Administrative staff should report to the Chief Administrative Officer.

This reorganization has caused a significant morale issue, further aggravated by the fact that the Director of Medicolegal Investigations provides little if any supervision of the Administrative Services personnel, has no administrative supervision experience and is frequently away from the office on OCME-related business. As a result, administrative personnel often seek out the Chief Administrative Officer for guidance and direction.

26. The Worcester and Holyoke offices should be integrated with the Boston Headquarters

The Worcester and Holyoke offices of the OCME function largely independent of the Boston headquarters, with little or no coordination or consistency. There is no common system that unites the offices. There is no common staff meeting that the branch pathologists attend. For example, the Medical Examiners in the Boston office have a morning and afternoon conference to discuss the casework for each day. However, the Worcester and Holyoke offices do not participate in these conferences. This may be a time management decision as their caseloads are far smaller than the caseload in Boston. However, staff in these offices would benefit from the discussion occurring at these meetings, particularly the afternoon meetings which have educational and quality assurance components.

There should be a fully integrated OCME in order to ensure uniformity and standardization of operations and systems. An information technology system that connects the Boston office with satellite offices and video conferencing should be considered. Policies and procedures, when developed, need to be communicated to these outlying offices.

27. The OCME should hire an evidence technician

There is no OCME employee presently responsible for handling and coordinating evidence received by the OCME with the bodies. While our review has found no deficiency in the manner in which evidence is being handled or stored, best practices requires the appointment of an evidence technician.

Until very recently, the OCME's evidence room was used as a repository for anything accompanying a body, whether or not it actually qualified as potential evidence in a criminal case or evidence which may aid in determining cause and manner of death. Items dating back in some instances almost 10 years, with the underlying criminal case long since having been disposed, remained in the evidence room. Also remaining in the evidence room were items that were not part of criminal cases, such as ligatures from suicides, where the decedent had long since been buried.

A Massachusetts State Police Lieutenant assigned to the OCME, working with the Morgue Supervisor and police departments across the Commonwealth, recently took on the responsibility of organizing and "cleaning out" the evidence room.

Coordinating evidence received by the OCME cannot and should not be the responsibility of the Massachusetts State Police. The OCME must hire an evidence technician who should have responsibility for all evidence received by the OCME. This person should work closely with the District Attorneys, police and the OCME's law enforcement liaison (discussed below) to establish written procedures for handling and storing evidence which comply with legal standards. Likewise, this person should be responsible for disposition and destruction of evidence when appropriate and pursuant to clearly established policies and guidelines.

28. The OCME must implement a contingency communication plan and communicate the plan to stakeholders

On a number of occasions, law enforcement officers at a death scene have been unable to contact the OCME during off hours. Two very recent incidents are illustrative of the problem. In the first, after being unable to reach anyone at the OCME during the middle of the night (two Morgue Technicians work during the overnight shift), the police contacted the First Assistant District Attorney for the county where they were based. He in turn contacted the Undersecretary for Forensic Science, who called the Chief Administrative Officer at home. The Chief Administrative Officer contacted one of the

assigned Morgue Technicians on his cellular phone. In another recent incident, the State Police, unable to reach anyone at the OCME again in the middle of the night, contacted a local State Police barracks located near the OCME, which sent a Trooper to the OCME. In both instances, the phone system at the OCME was down.

Even had such incidents not happened enough times that they should by now be anticipated, the OCME should have a contingency communication plan. Relevant contact information for the Morgue Supervisor and overnight shift personnel should be shared with the law enforcement community, as should the order of contact.

29. The OCME should establish a "law enforcement liaison" position

There is presently no one at the OCME designated to function as a liaison to the law enforcement community. This has led to frustrations and delays for the law enforcement community seeking to obtain information from the OCME. Access to information is largely dictated by pre-existing personal relationships.

There is a Massachusetts State Police Lieutenant assigned to the OCME, but not on the OCME staff, who among other things assists the OCME Medical Examiners to obtain necessary police reports and handles evidence issues. The law enforcement liaison role, though, contemplates a different function.

There should be a position created in the OCME to serve as a liaison to the District Attorneys and police. This OCME employee would coordinate all matters relating to criminal investigations/trials, including, among other functions, the scheduling of autopsies (in many instances police wish to attend autopsies in furtherance of their investigation), status of autopsy reports and scheduling trial preparation and trial dates with the Medical Examiners.

30. The OCME should establish a "family liaison" position

There is presently no OCME staffer designated as the principle point of contact for families of the deceased or funeral homes acting on behalf of the families. To date, the OCME has handled providing information to these groups in an ineffective fashion. The quality of service and information a family member will receive is largely dependent on who, by happenstance, answers the phone at the OCME. This is an area where the OCME, an agency intended to serve the people of the Commonwealth, has its greatest

contact with the general public and, accordingly, resources should be allocated to assure this contact is handled effectively and with the requisite sensitivity.

Timely dissemination of information concerning the remains of a loved one must be handled with sensitivity and care. Creation of a family liaison position in the OCME with specific duties and responsibilities should be undertaken. This staffer should also be charged with interfacing with families of the deceased and with funeral home directors involved in the removal of those bodies to the OCME.

31. The OCME must devise a process to better handle supply and equipment ordering

The medical supply and equipment ordering process has been and continues to be an issue at the OCME. The OCME has great difficulty monitoring and stocking its inventory of basic health and safety supplies - face shields, cut gloves, etc. – used by the Medical Examiners and Morgue Technicians during autopsies.

A single OCME staffer should be responsible for monitoring these items and re-supplying them before they run out and the remaining OCME staff should be advised of who will have this responsibility. This simple process of assuring personal protective devices which reduce biohazard and other risks cannot continue to be handled the way it has been handled

VI. Conclusion

The problems facing the Office of the Chief Medical Examiner will continue to worsen if immediate changes are not made and steps are not taken to reorganize and rebuild this agency.

This rebuilding process can only be effectively spear-headed by an experienced and independent Chief Operating Officer, working with the Chief Medical Examiner.

By virtue of the work it performs, the OCME is a difficult place to work under the best of circumstances. While most of the staff overall are working hard under very difficult conditions, supervision must be increased and immediate steps need to be taken to prevent the OCME from being overtaken by a creeping culture of indifference and a completely demoralized staff.

This is an agency which, given the increased funding, the strong support from its stake-holders and recent additions of excellent staff, should not be in the condition it is today. What brought it here is a very unique set of circumstances. What will revitalize it is recognition of the uniqueness of the circumstances, the continued support for the critical mission it performs and strong and capable leadership.